Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
1415 SOUTH HWY 6 SUITE 400D
SUGARLAND TEXAS 77478

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-10-2725-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the *Table of Disputed Services*: "Fee Guideline"

Amount in Dispute: $128.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2009	Evaluation and Management	$128.54	$128.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the procedures for professional medical services provided in the Texas workers' compensation system on or after March 1, 2008.
3. Request for reconsideration letter dated December 16, 2009, states in part "On October 16, 2009 we submitted the attached HCFA form with the supporting documentation related to the date of service August 25, 2009 for payment processing. However, as of today we have yet to receive a payment or a response. The dispute did not contain EOBs pertaining to the disputed charge. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

Issues

1. Did the requestor bill the services in accordance with 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.
2. Review of the CMS-1500 indicates that the requestor billed the following CPT code:
   - CPT code 99214
3. CPT code 99214 is defined as an office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key components. Review of the documentation titled *Occupational Medicine Follow Up* documents the minimum requirements for billing CPT code 99214. Therefore the requestor is entitled to reimbursement of the disputed charge.
4. 28 Texas Administrative Code §134.203(c)(1) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied…"
5. Reimbursement is therefore calculated with conversion factor $53.68 to determine the maximum allowable reimbursement (MAR).
   - CPT code 99214
   - CMS reimbursement $87.69 + applied conversion factor of $53.68
   - MAR-$130.51
   - Amount Sought $128.54

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $128.54.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $128.54 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 3, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.